MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06771

CERTIFICATE OF DEATH

06759

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: KENT
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN
c. LENGTH OF STAY IN 1b: SIX DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KENT AND QUEEN ANNE'S HOSPITAL, INC.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN (15 Yrs.)
d. STREET ADDRESS: 103 NORTH MILL STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAY Middle FRED Last ALLEGER

4. DATE OF DEATH: Month MAY Day 12 Year 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/15/00

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CUSTODIAN

10b. KIND OF BUSINESS OR INDUSTRY: CHRIST METHODIST CHURCH

11. BIRTHPLACE (County & State, or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? US.

13. FATHER'S NAME: EUGENE ALLEGER

14. MOTHER'S MAIDEN NAME: MALVINA CUSTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 166-07-2465

17. INFORMANT: HOSPITAL RECORDS Address: CHESTERTOWN, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): PLEURESY — Few Weeks
DUE TO (c): CARCINOMA OF LUNG — Few Months
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from MAY 6, 1967, to MAY 12, 1967, that (I) (we) last saw the deceased alive an MAY 12 1967, and that death occurred at 9:40 A.M. from causes and on the date stated above.

22a. SIGNATURE: Jorge A. Oteiza — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-12-67

22c. PHYSICIAN'S NAME (Type): DR. J.A. OTEIZA

22d. ADDRESS: CHESTERTOWN, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/15/67

23c. NAME OF CEMETERY OR CREMATORY: Chester Cem.

23d. LOCATION (City or Town) (County) (State): Chestertown, Md.

24. FUNERAL DIRECTOR: J Willis Wells — ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: MAY 16 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06772

CERTIFICATE OF DEATH

06760

1. PLACE OF DEATH
a. COUNTY: Kent County, Maryland — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): R.F.D. Chestertown, Md.
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): At the home of Mrs. Lena Williams

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R.F.D. Chestertown, Maryland
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Annie — Middle: — Last: Bell

4. DATE OF DEATH: Month: 5 — Day: 5 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1/5/1880

9. AGE (In years last birthday): 87 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: Various

11. BIRTHPLACE (County & State, or foreign country): Kent County, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Blake

14. MOTHER'S MAIDEN NAME: Sally Hopkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 212-40-9167

17. INFORMANT — Address: Mrs. Lena Williams Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): A.S.C.V.D
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 3-30, 1967, to 4-28, 1967, that (I) (we) last saw the deceased alive on 4-28 1967, and that death occurred at [illegible] M, from the causes and on the date stated above.

22a. SIGNATURE: Harry Paul Ross M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-6-67

22c. PHYSICIAN'S NAME (Type): Harry Paul Ross M.D.

22d. ADDRESS: Chestertown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/8/1967

23c. NAME OF CEMETERY OR CREMATORY: Janes Cemetery

23d. LOCATION (City, town or county) (State): R.F.D. Chestertown, Md.

24. FUNERAL DIRECTOR: Bennett Valley

ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: MAY 9 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
2DM 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06773 — Reg. Dist. No. 06761

1. PLACE OF DEATH
a. COUNTY: Kent County, Maryland — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R. Chestertown, Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: In Doctor's Office

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Maryland
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R.F.D.#1 Chestertown, Maryland
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mattie — Middle: — Last: Benjamin

4. DATE OF DEATH: Month: 5 — Day: 10 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

B. DATE OF BIRTH: 10/9/ 1890

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: Various

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lee Dent

14. MOTHER'S MAIDEN NAME: Mary E.Holley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-14-4013

17. INFORMANT — Address: Mr.Linwood Lively Sr. Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral vascular hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: 1½ hrs.
DUE TO
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): History of previous attack 1 year ago.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/2/67, 19 67, to 5/10, 19 67, that I last saw the deceased alive on 5/10, 19 67, and that death occurred at 4:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas J Solon M.D.
ADDRESS (Street, city or town, state): 500 Kent Street
DATE SIGNED: 5/10/67

PHYSICIAN'S NAME (Type): Thomas J. Solon, M. D.
Chestertown, Md. 21620

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/14/1967
22c. NAME OF CEMETERY OR CREMATORY: Joshua Chaple Cem.
22d. LOCATION (City, town, or county) (State): R.F.D. Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Lennetta Colby
ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: MAY 16 1967
24b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be signed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06774 05762

1. PLACE OF DEATH
a. COUNTY: Kent
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Betterton
c. LENGTH OF STAY IN 1b: lifetime
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Betterton
d. STREET ADDRESS: 14-1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Nelson Middle Leroy Last BOONE
4. DATE OF DEATH: Month May Day 15, Year 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan. 31, 1905
9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Heavy Equiptment Operator (Retired)
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Kent Co. Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John E. Boone
14. MOTHER'S MAIDEN NAME: Mattie Leigh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 220 12 2435
17. INFORMANT Address: Mrs. Hattie Wyble - Betterton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: 10 min.
416 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Probable pulmonary infarction — 10 min.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Mitral insufficiency.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 21, 1956 to May 15, 1967, that (I) (we) last saw the deceased alive on 5/15/67 19, and that death occurred at 9:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Thomas J. Solon M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/16/67
22c. PHYSICIAN'S NAME (Type): Thomas J. Solon
22d. ADDRESS: Chestertown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/18/67
23c. NAME OF CEMETERY OR CREMATORY: Still Pond Cem
23d. LOCATION (City, town or county) (State): Still Pond, Md.

24. FUNERAL DIRECTOR: J. Willis Wells
ADDRESS: Chestertown, Md.
25a. REC'D BY REGISTRAR DATE: MAY 18 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06775 06763

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Millington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millington
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nora; Middle:; Last: Bowers

4. DATE OF DEATH: Month: May; Day: 20; Year: 1967

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 1, 1907

9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alex Bowers

14. MOTHER'S MAIDEN NAME: Amelia Stanley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 218-24-7269HA

17. INFORMANT: James Wells — Address: Millington, Maryland. 21651

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio vascular insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 2 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Rheumatic heart disease
DUE TO (c): Chronic Rheumatic fever.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11-5-66, 19__, to 5-19-, 1967, that (I) (we) last saw the deceased alive on 5-19- 1967, and that death occurred at 1A M, from the causes and on the date stated above.

22a. SIGNATURE: Rudolfs Eglitis M.O. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-22-67

22c. PHYSICIAN'S NAME (Type): Rudolfs Eglitis, M.D.

22d. ADDRESS: Roosevelt, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 24, 1967

23c. NAME OF CEMETERY OR CREMATORY: Davis Hill Cemetery

23d. LOCATION (City, town or county) (State): Galena, Maryland

24. FUNERAL DIRECTOR: Edward Fellows — ADDRESS: Millington, Maryland

25a. REC'D BY REGISTRAR — DATE: MAY 25 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06776 — 05764

1. PLACE OF DEATH
a. COUNTY: Kent County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent-Queen Anne's Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown 14-1
d. STREET ADDRESS: Route #3
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Joseph Middle Wesley Last Brown
4. DATE OF DEATH: Month May Day 12 Year 1967
5. SEX: M
6. COLOR OR RACE: N
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-4-1887
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months | Days 8
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ret. farmer
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (County & State, or foreign country): Kent Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Alexander Brown
14. MOTHER'S MAIDEN NAME: Mary Anna Graves

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give wor or dotes of service): -
16. SOCIAL SECURITY NO.: YES
17. INFORMANT Address: Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): STROKE & Lt. hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO (b): A.S.C.V.D
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Haur o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 5-2-, 1967, to 5-12, 1967, that (I) (~~we~~) last saw the deceased alive on 5-12 1967, and that death occurred at 8:30 p M, from causes and on the date stated above.

22a. SIGNATURE: Harry P Ross — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-13-67
22c. PHYSICIAN'S NAME (Type): Dr Harry P. Ross
22d. ADDRESS: Chestertown, Md 21620

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 5/16/67
23c. NAME OF CEMETERY OR CREMATORY: EMMANUEL MET. CEM.
23d. LOCATION (City or Town) (County) (State): R.F.D. #3 Chestertown, Md

24. FUNERAL DIRECTOR: Emmett Colby — ADDRESS: Chestertown, Md
25a. REC'D BY REGISTRAR DATE: MAY 17 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06777 06765

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Chestertown, Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Kent & Queen Anne Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall, Md.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Rosetta Middle: Last: Coxon

4. DATE OF DEATH: Month: May Day: 5 Year: 1967

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/3/1901

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James F. Baker

14. MOTHER'S MAIDEN NAME: Susan Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 215 20 0198

17. INFORMANT Address: Henry J. Coxon Rock Hall, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 12 HRS

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): HYPERTENSION — SEV. YEARS
DUE TO (c): OBESITY. — SEV. YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-12-, 1967, to 5-5, 1967, that (I) (we) last saw the deceased alive on 5-5- 1967, and that death occurred at 10:45 AM, from the causes and on the date stated above.

22a. SIGNATURE: Jorge Otero M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-5-67

22c. PHYSICIAN'S NAME (Type): Jorge A. Otero

22d. ADDRESS: Chestertown, Md. 21620

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/7/67

23c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel Cem

23d. LOCATION (City, town or county) (State): Rock Hall, Md.

24. FUNERAL DIRECTOR: J. Willis Wells ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: MAY 8 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06778

CERTIFICATE OF DEATH

06766

1. **PLACE OF DEATH**
   a. COUNTY: Kent — MARYLAND
   b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Chestertown
   c. LENGTH OF STAY IN 1b: 12 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Anne's Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Kent
   c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Rock Hall
   d. STREET ADDRESS: None
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Hiram — Middle: Jonas — Last: Crew

4. **DATE OF DEATH**: Month: 5 — Day: 24 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/25/1884

9. AGE (In years last birthday): 82 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Chestertown Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: William Crew

14. MOTHER'S MAIDEN NAME: Mollie Pierce

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
   (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 215-20-1103

17. **INFORMANT**: Hospital Records — Address: Chestertown, Md. 21620

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Arteriosclerotic Cardio-Vascular
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b): Fibrillation
   DUE TO
   (c): Have talked to Attending M.D. as well as autopsy Surgeon - Robert W. Farr - Med Examiner Kent County

   INTERVAL BETWEEN ONSET AND DEATH

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture Left Femoral Neck

   19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

   20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell at home

   20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. APR 7 19 67

   20d. INJURY OCCURRED While at work ☐ Not While at work ☒

   20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

   20f. (City or town): Rock Hall (County): Kent (State):

   21. **I certify** that (I) (this hospital) attended the deceased from 5/12, 19 67, to 5/24, 19 67 that (I) (we) last saw the deceased alive an 5/24, 19 67, and that death occurred at 3:20 A.M, from causes and on the date stated above.

   22a. SIGNATURE: A. T. Keefe M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

   22b. DATE SIGNED: 5-24-67

   22c. PHYSICIAN'S NAME (Type): Dr. A. T. Keefe

   22d. ADDRESS: Chestertown, Maryland 21620

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 26

23c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel

23d. LOCATION (City or Town) (County) (State): Rock Hall, Maryland

24. FUNERAL DIRECTOR: Edgar L. Lane — ADDRESS: Church Hill, Md.

25a. FILED BY REGISTRAR — DATE: MAY 29 1967

25b. REGISTRAR'S SIGNATURE: [illegible] Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06773 06767

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Kent
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: short
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Kent & Queen Anne

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kennedyville
d. STREET ADDRESS: Kentmore Park
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Wellington Middle Earl Last Duke Sr.

4. DATE OF DEATH: Month May Day 24, Year 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 29, 1904

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): R tired Electrician

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Yonkers. N.Y.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Francis Duke

14. MOTHER'S MAIDEN NAME: Jeanette Gould

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 179 01 1286

17. INFORMANT: Elfrieda D. Duke - Kennedyville, Md.
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: years
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): with symptoms and history highly sug- — 1 hr.
DUE TO (c): gestive of a Massive coronary infaret

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-24-67, 19__, to 5-24-67, 19__, that (I) (we) last saw the deceased alive on 5-24 19 67, and that death occurred at 9:45 P.M., from the causes and on the date stated above.

22a. SIGNATURE: A. C. Dick M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/24/67

22c. PHYSICIAN'S NAME (Type): A. C. Dick

22d. ADDRESS: Chestertown, Md. 21620

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/27/67

23c. NAME OF CEMETERY OR CREMATORY: Crumpton Cem.

23d. LOCATION (City, town or county) (State): Crumpton, Md.

24. FUNERAL DIRECTOR: J. Wills Wells ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: MAY 29 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06780

CERTIFICATE OF DEATH

06768

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 529 High St.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
d. STREET ADDRESS: 529 High St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Olie — Middle — Last Ford
4. DATE OF DEATH: Month May — Day 24, — Year 1967
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 27, 1879
9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Merritt Ford
14. MOTHER'S MAIDEN NAME: Hester Newnam

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 220 34 9954
17. INFORMANT: Bessie Ford — Address: Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Complications of old age — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b):
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August 10, 1965, to May 24, 1967, that (I) (we) last saw the deceased alive on 5-20 1967, and that death occurred at 2 3/4 M, from the causes and on the date stated above.

22a. SIGNATURE: A. C. Dick M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/24/67
22c. PHYSICIAN'S NAME (Type): A. C. Dick
22d. ADDRESS: Chestertown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/26/67
23c. NAME OF CEMETERY OR CREMATORY: Galena Cemetery
23d. LOCATION (City, town or county) (State): Galena, Maryland

24. FUNERAL DIRECTOR: J. Willis Wells — ADDRESS: Chestertown, Md.
25a. REC'D BY REGISTRAR DATE: MAY 29 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

VR A15 (4)
2DM 1/65

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06781 — 06769

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Anne Hospital (2hrs)

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown Lifetime
d. STREET ADDRESS: 103 Pine St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DAVID — Middle J. — Last FOWLER
4. DATE OF DEATH: Month May — Day 14 — Year 19 67

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 29, 1949
9. AGE (In years last birthday): 18 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student & Radio announcer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cecil Co. Maryland
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: John Fowler
14. MOTHER'S MAIDEN NAME: Fay Chance

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
16. SOCIAL SECURITY NO. (If yes give wor or dates of service): 220 52 0298
17. INFORMANT — Address: John Fowler - Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fracture base of skull - severe
DUE TO (b): Auto accident. ~~Body found in field some distance from auto. Brought to hospital by rescue squad. Course was rapidly downhill.~~
DUE TO (c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
INTERVAL BETWEEN ONSET AND DEATH: 2 3/4 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m.: 5/14 67 — 12:45 xx
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): highway
20f. (City or town): near Lynch (County): Kent (State): Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural couses ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: Robert W. Farr
EXAMINER'S NAME (Type): Robert W. Farr
Address (Street, city, town, or county): Chestertown Kent Co. Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 5/14/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/16/67
23c. NAME OF CEMETERY OR CREMATORY: St. Paul Cem. near
23d. LOCATION (City or Town) (County) (State): Chestertown, Md.

24. FUNERAL DIRECTOR: J. Willis Wells
ADDRESS: Chestertown, Md.
25a. REC'D BY REGISTRAR DATE: MAY 18 1967
25b. REGISTRAR'S SIGNATURE: [signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06782 — 06770

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Kent — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Kent
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown — c. LENGTH OF STAY IN 1b: 45 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Anne's Hospital	d. STREET ADDRESS: None — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Lost	4. DATE OF DEATH Month	Day	Year
Florence	May	Francis	5	26	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White		9/18/1883	83 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	US

13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Walton	Sutton	Emma	Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	220-16-9699	Hospital Records	Chestertown, Md. 21620

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis due to — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) metastatic carcinoma from left breast — 6 months
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/11, 19 67, to 5/26, 1967, that (I) (we) last saw the deceased alive on 5/26 19 67, and that death occurred at 3:25 A.M., from causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22b. DATE SIGNED
A. C. Dick M.D.	☐	☐	☐	5-26-67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Dr. A. C. Dick	Chestertown, Maryland 21620

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	5/29/67	St. Paul Cemetery	Near - Chestertown, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
J. Willis Wells	Chestertown, Md.	MAY 31 1967	J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06783 06771

FOR STATE HEALTH DEPT. USE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Kent
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 39 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Annes

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Delaware
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Smyrna
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle Last GRAHAM

4. DATE OF DEATH: Month May Day 8 Year 19 67

5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov 7, 1917
9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor
10b. KIND OF BUSINESS OR INDUSTRY: Various
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Coleman Graham
14. MOTHER'S MAIDEN NAME: Stella Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: Yes
17. INFORMANT Address: Hospital records, Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemoperitoneum — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Contusion of liver and spleen
DUE TO
(c): Multiple fractures of ribs, right

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Sustained in aout accident
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.: about 1 p.m. 5/7/67 19
20d. INJURY OCCURRED White at work ☐ Not White at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): highway
20f. (City or town) (County) (State): nr Sudlersville QA Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Robert W. Farr M.D.
EXAMINER'S NAME (Type): Robert W. Farr
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Kent Co
22. DATE SIGNED: 5/9/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/15/1967
23c. NAME OF CEMETERY OR CREMATORY: Odd Fellow's Cem.
23d. LOCATION (City or Town) (County) (State): Smyrna Del

24. FUNERAL DIRECTOR: Bennett Wolf
ADDRESS: Chestertown, Md.
25a. REC'D BY REGISTRAR DATE: MAY 10 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06784 — 06772

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Kent County, Maryland — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): R.F.D. Chestertown, Md.
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): At the home of her Daughter

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland, b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R.F.D. Chestertown, Maryland
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Minnie — Middle: B. — Last: Grinnell

4. DATE OF DEATH: Month: 5 — Day: 1 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/3/1886

9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: Various

11. BIRTHPLACE (County & State, or foreign country): Kent County, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Randell Jackson

14. MOTHER'S MAIDEN NAME: Violet Grayson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 215-36-1147-B

17. INFORMANT: Mrs. Ruth Thompson — Address: R.F.D. Box 71 Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebro-Vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 4 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arterio-Sclerosis
DUE TO (c): Old age

331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6-6-, 1963, to 4-28, 1967, that (I) (we) last saw the deceased alive on 4-28 1967, and that death occurred at 10 PM, from the causes and on the date stated above.

22a. SIGNATURE: Rudolfs Eglitis — M.O. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-3-67

22c. PHYSICIAN'S NAME (Type): Rudolfs Eglitis M.D.

22d. ADDRESS: Rock Hall, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/6/1967

23c. NAME OF CEMETERY OR CREMATORY: Asbury Methodist Cem.

23d. LOCATION (City, town or county) (State): R.F.D. Chestertown, Md.

24. FUNERAL DIRECTOR: Kenneth Wadey — ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR: MAY 9 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 20M 1/65

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06785 — 06773

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Chestertown
c. LENGTH OF STAY IN 1b: lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Quaker Neck Section

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Chestertown
d. STREET ADDRESS: Quaker Neck Sec.
e. IS RESIDENCE ON A FARM? YES XX NO ☐

3. NAME OF DECEASED (Type or print): First Robert — Middle J. — Last Hickman Jr.

4. DATE OF DEATH: Month May — Day 22 — Year 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED XX — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 3/9/27

9. AGE (In years last birthday): 40 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Kent Co. Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert J. Hickman

14. MOTHER'S MAIDEN NAME: Miriam Keeley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 221 14 7315

17. INFORMANT — Address: Eleanor F. Hickman Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: short
974X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Suicide by hanging.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Self inflicted

20c. TIME OF INJURY Month, Day, Year: Hour a.m. / p.m. 9 PM 5-22 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home

20f. (City or town) Rural (County) Chestertown (State) Kent Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Robert W Earr
EXAMINER'S NAME (Type): Robert W. Earr
Address (Street, city, town, or county): Chestertown Kent Co. Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 5/23/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/25/67
23c. NAME OF CEMETERY OR CREMATORY: Chester Cem.
23d. LOCATION (City or Town) (County) (State): Chestertown, Md.

24. FUNERAL DIRECTOR: J Willis Wells — ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR: MAY 26 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06786

CERTIFICATE OF DEATH

06774

1. PLACE OF DEATH
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town): RURAL ROCK HALL
c. LENGTH OF STAY IN 1b: 12 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospitol, give street address): SKINNER'S NECK

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: KENT
c. CITY OR TOWN (If outside corparate limits, write RURAL and give neorest town): RURAL ROCK HALL
d. STREET ADDRESS: SKINNER'S NECK
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SARAH Middle VIRGINIA Lost JONES
4. DATE OF DEATH: Month MAY Doy 14 Year 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: APRIL 16, 1895
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months ___ Doys ___
IF UNDER 24 HRS.: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (County & Stote, or foreign country): CENTREVILLE, Q.A.Co., Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: GEORGE WASHINGTON HARRIS
14. MOTHER'S MAIDEN NAME: SARAH VIRGINIA SLAUGHTER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.: 218-20-3215
17. INFORMANT Address: WILLIAM JONES, ROCK HALL, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Hypertension
Conditions, if ony, which gove rise to immediate cause (a), stoting the underlying couse lost. DUE TO (c): Cardio Vascular Diabetes
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept 28, 1953, to May 14, 1967, that (I) (we) last saw the deceased alive an May 12, 1967, and that death accurred at 5,45 PM, from causes and on the date stated abave.

22a. SIGNATURE: Norbert C Nitsch — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): NORBERT-C NITSCH
22d. ADDRESS: ROCK-HALL-MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: MAY 17, 1967
23c. NAME OF CEMETERY OR CREMATORY: Chesterfield Cemetery
23d. LOCATION (City or Town) (County) (State): CENTREVILLE, Q.A.Co. Md
24. FUNERAL DIRECTOR: James W. Barton Jr. — ADDRESS: Barton Bros, Centreville, Md.
25a. RECD BY REGISTRAR DATE: MAY 18 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 4 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06787 06775

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Worton
c. LENGTH OF STAY IN 1b: 40 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Cath Comm

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Worton
d. STREET ADDRESS: Cath Comm
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert Middle: A. Last: Loud
4. DATE OF DEATH: Month: May Day: 29 Year: 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 23 1891
9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Grain & feed
11. BIRTHPLACE (County & State, or foreign country): Fairlee Kent Co. Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Edward Loud
14. MOTHER'S MAIDEN NAME: Rachel Maslin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 216-09-6022
17. INFORMANT: Mrs Ethel R. Loud Address: Worton Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Thrombosis	Short
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerotic cardiovascular disease	several years
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (Stete)

21. I certify that (I) (this hospital) attended the deceased from 1/26, 1961, to 5/29, 1967, that (I) (we) last saw the deceased alive on 5/29 1967, and that death occurred at 4 A M, 30 from the causes and on the date stated above.

22a. SIGNATURE: Robert Farr M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: ~~5/31~~ 6/1/67
22c. PHYSICIAN'S NAME (Type): Robert W. Farr, M. D.
22d. ADDRESS: Chestertown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 1 1967
23c. NAME OF CEMETERY OR CREMATORY: Chester Cemetery
23d. LOCATION (City, town or county) (State): Chestertown Kent Co Md.
24. FUNERAL DIRECTOR: Mann E. Williams ADDRESS: Chestertown Md
25a. REC'D BY REGISTRAR DATE: JUN 5 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06785 06776

1. PLACE OF DEATH
a. COUNTY: Kent MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): ~~107 High St.~~ Kent & Queen Anne

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
d. STREET ADDRESS: 107 High St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Jesse Middle W. Last Moffett
4. DATE OF DEATH: Month May Day 23, Year 1967
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Mar. 9, 1901
9. AGE (In years last birthday): 66 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Schoolteacher
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Kent CO. Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Pearly Moffett
14. MOTHER'S MAIDEN NAME: Sarah Pennington
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 207 16 3007
17. INFORMANT: Margaret S. Moffett Address: Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2½ hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic cardiovascular disease — several years
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/5/66, 19__, to 5/23, 1967, that (I) (we) last saw the deceased alive on 5/23/1967, and that death occurred at 2 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Robert W. Farr M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/23/67
22c. PHYSICIAN'S NAME (Type): Robert W. Farr
22d. ADDRESS: Chestertown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/25/67
23c. NAME OF CEMETERY OR CREMATORY: Old Bohemia Cem.
23d. LOCATION (City, town or county) (State): Warick, Md.

24. FUNERAL DIRECTOR: J. Willis Wells ADDRESS: Chestertown, Md.
25a. REC'D BY REGISTRAR DATE: MAY 29 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06783

CERTIFICATE OF DEATH

06777

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Kent — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: Kent
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown	c. LENGTH OF STAY IN 1b: 34 days
	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Betterton Still Pond
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Anne's Hospital	d. STREET ADDRESS: None — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Grace	Gertrude	Rasin	5	29	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White		1/8/1887	80 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	HOME	Maryland	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas F. Rasin	Alice Jewell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give wor or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	—		Hospital Records	Chestertown, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARCINOMATOSIS	FEW WEEKS
DUE TO (b)	CARCINOMA OF Rt. BREAST operated	4 YEARS
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)			
20c. TIME OF INJURY Month, Doy, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at wark ☐	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from ~~5x~~ 4/25, 1967, to 5/29, 1967, that (I) (we) last saw the deceased alive on 5/29 1967, and that death occurred at 1:30 P.M., from causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22b. DATE SIGNED
Dr. Oteiza					5/29/67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Dr. Jorge Oteiza	Chestertown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
BURIAL	6-1-67	STILL POND CEMTY	STILL POND	KENT	MD

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Victor N. Kennedy	STILL POND, MD.	JUN 1 1967	J. Charles Judge

FOR STATE HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06790

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06778

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Exominer's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: Kent	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland	b. COUNTY: Kent
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Worton	c. LENGTH OF STAY IN 1b: 30 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Worton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Annes Emergency Room		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Dorothy	Lyle	Schnoor	May	8	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White		Sep 22 1903	63 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper & Avon	Saleswomen	New York	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Maxwell Byrd	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	220 14 4843	Otto SCHNOOR , Worton, Md. (husband)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Arteriosclerotic Cardiovascular Disease	1 month
DUE TO (b)	Had an attack while sitting in a chair, and slumped over unconscious. Just before, had complained of indigestion	
DUE TO (c)	Manner of death resembled cardiac arrest. Time- 11:30 PM	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Robert W. Farr M.D.

EXAMINER'S NAME (Type) Robert W. Farr

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county) Kent County

22. DATE SIGNED 5/8/67

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	5/11/67	Chester Cem.	Chestertown, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. ACCEPTED BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
J. Willis Wells Chestertown, Md.	MAY 12 1967	Jeanne S. Judge

VR A15ME (5)
6M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06791

CERTIFICATE OF DEATH

06779

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown,
c. LENGTH OF STAY IN 1b: 20 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): High St.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
d. STREET ADDRESS: 541 High St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Homer — Middle B. — Last Simpkins

4. DATE OF DEATH: Month May — Day 30 — Year 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 1/2/1887

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Iron worker and builder (ret)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: David Simpkins

14. MOTHER'S MAIDEN NAME: Elmira Baxter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 220 26 2772

17. INFORMANT: Mrs. Esther Dean, Address 15 S. Morton Ave, Morton, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Complications of old age
DUE TO (b):
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 26, 1962 to 5-30, 1967, that (I) (we) last saw the deceased alive on 5-25 1967, and that death occurred at 8:45 A.M. from the causes and on the date stated above.

22a. SIGNATURE: A. C. Dick M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/30/67

22c. PHYSICIAN'S NAME (Type): A. C. Dick

22d. ADDRESS: Chestertown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/3/67

23c. NAME OF CEMETERY OR CREMATORY: St. Paul Cemetery

23d. LOCATION (City, town or county) (State): near Chestertown, Md.

24. FUNERAL DIRECTOR: J. Willis Wells ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: JUN 2 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65